

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3381

CERTIFICATE OF DEATH

Reg. Dist. No.

03365

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARTFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARTFORD Memorial</u>		d. STREET ADDRESS <u>Bush Chapel Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Joseph</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 June 1957</u>
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Dwight Adams</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Vesely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>*** **</u>	
17. INFORMANT <u>James D. Adams</u>		Address <u>R.D. #1, Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, diffuse, both lungs</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>48 hr</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-23-</u> , 19 <u>58</u> , to <u>5-23-</u> , 19 <u>58</u> that I last saw the deceased alive on <u>5-23-</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8 LAW ST. Aberdeen, Md.</u> DATE SIGNED <u>3-24-58</u>			
ACTUAL SIGNATURE <u>Peter P. Rodman, MD</u>		M.D. <u>8 LAW ST. Aberdeen, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Fanning</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
James L. Adams		Male		60		June 28, 1927		Maryland		June 28, 1957		Baltimore, Maryland		Heart Disease		Natural		[Signature]		[Signature]	
R.D. Adams		Male		60		June 28, 1927		Maryland		June 28, 1957		Baltimore, Maryland		Heart Disease		Natural		[Signature]		[Signature]	

BUREAU V. S.

MAR 27 1958

RECEIVED

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3401 CERTIFICATE OF DEATH

03367

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>RURAL - BEL AIR</u>		<u>20 years</u>		TOWN <u>RURAL - BEL AIR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD BEL AIR</u>				STREET ADDRESS (If rural give location) <u>NEAR HICKORY</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EFFIE</u> (Middle) <u>ALA</u> (Last) <u>ANDERSON</u>				(Month) <u>MARCH</u> (Day) <u>4</u> (Year) <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Wid</u>	8. DATE OF BIRTH <u>JUNE 18, 1889</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas Newton BLEVINS</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>ELMER R ANDERSON, BEL AIR, MD</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170x IMMEDIATE CAUSE (A) <u>BRONCHOPNEUMONIA</u>						<u>3 or 4 days</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>METASTATIC CARCINOMA in Lung and pleura</u>						<u>6 to 8 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARCINOMA of BREAST</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>NOV. 28</u> , 19 <u>52</u> , to <u>MAR. 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 3</u> , 19 <u>58</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Stonewall Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE., BEL AIR MD</u>			
DATE SIGNED <u>3/4/58</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/7/58</u>		NAME OF CEMETERY OR CREMATORY <u>ROCK SPRING BAPTIST</u>		LOCATION (City, town, or county) (State) <u>LANCASTER PA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Paul S. Stonewall Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		ADDRESS <u>Bel Air, MD</u>	
DATE <u>MAR 7 '58</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3382

CERTIFICATE OF DEATH

Reg. Dist. No. **03368**

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 400 S. MAIN ST.	
3. NAME OF DECEASED (Type or print) W. Sanner First Bailey Middle Bailey Last		4. DATE OF DEATH March 18 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Mill Operator		10b. KIND OF BUSINESS OR INDUSTRY OWNER	9. AGE (In years last birthday) 66 yrs.
11. BIRTHPLACE (State or foreign country) Churchville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas V. Bailey		14. MOTHER'S MAIDEN NAME Sallie J. Schultz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 7-20-18-7042 219-28-9959	
17. INFORMANT Mrs. Hattie V. Bailey		Address 400 S. Main St., Bel Air, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-18 , 19 58 , to 3-18 , 19 58 , that I lost saw the deceased alive on 3-18 , 19 58 , and that death occurred at 11 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gerald C Palmer M.D.		ADDRESS (Street, city or town, state) Bel Air, Md. DATE SIGNED 3-18-58	
PHYSICIAN'S NAME (Type) Gerald C Palmer MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF March 21, 1958	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph William Foster ADDRESS W. Broadway BEL AIR, Maryland		24a. REC'D BY REGISTRAR MAR 20 58 DATE	24b. REGISTRAR'S SIGNATURE W. Sanner

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VS A155 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3402

CERTIFICATE OF DEATH

Reg. Dist. No.

03369

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural. ROCKS</u>		LENGTH OF STAY (in this place) <u>7 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ROCKS OF DEER CREEK REST HOME</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (Type or Print) <u>NANCY</u> (First) (Middle) (Last) <u>BOYER</u>				4. DATE OF DEATH <u>MARCH 1</u> 19 <u>58</u> (Month) (Day) (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>JULY 29, 1928</u>	9. AGE last birthday <u>29</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard C. Springer</u>				14. MOTHER'S MAIDEN NAME <u>Florence Carpenter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Wm. W. Boyer, Perryman, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
345X IMMEDIATE CAUSE (A) <u>PNEUMONIA</u>						2 DAY	
ANTECEDENT CAUSE(S) DUE TO (B) <u>INCREASING SPASTIC PARALYSIS AND ULCERS</u>						1 YR.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>MULTIPLE SCLEROSIS</u>						OVER 5 YRS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>493X</u>				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1957</u> , to <u>March 1, 1958</u> , that I last saw the deceased alive on <u>Feb. 26, 1958</u> , and that death occurred at <u>10:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thelma W. Newman</u>		M.D. <u>307 HICKORY, BELAIR, Md</u>		DATE SIGNED <u>MARCH 1, 58</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/4/58</u>		NAME OF CEMETERY OR CREMATORY <u>Spesutia</u>		LOCATION (City, town, or county) (State) <u>Perryman, Md.</u>	
24. REC'D BY REGISTRAR <u>MAR 6 '58</u>		REGISTRAR'S SIGNATURE <u>W. Beach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. W. Boyer</u>		ADDRESS <u>Harford, Md.</u>	

CERTIFICATE OF DEATH

REG. DIST. NO.

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

RECEIVED

BURKAW V. B.

MAR 6 1958

RECEIVED

CERTIFICATE OF DEATH

03370

Reg. Dist. No.

3403

1. PLACE OF DEATH

COUNTY Harford MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Rural Bel Air
 TOWN Bel Air 3 years
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford
 CITY (If outside corporate limits, write RURAL and give nearest town) Bel Air
 TOWN Bel Air
 STREET ADDRESS 1 (If rural give location)

3. NAME OF DECEASED (Type or print)

(First)

(Middle)

(Last)

SARAH

Elizabeth

Brookhart

4. DATE OF DEATH

(Month)

(Day)

(Year)

March

3

1958

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED,

8. DATE OF BIRTH

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Female

White

Widow

June 21, 1885

72

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

House Wife

Home

Maryland

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

William Henry Daughton

Katherine Nixon Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

No

217-18-63404

Mrs. George E. Geyer

3113 Abell Ave. Balto. Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

420.1 IMMEDIATE CAUSE (A) Coronary thrombosis
 ANTECEDENT CAUSE(S) DUE TO
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive cardio-vascular disease
 (C)

Sudden

8 years

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21a. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1948, to March 3, 1958, that I last saw the deceased alive on March 2, 1958, and that death occurred at 10:00A M, from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

William P. Hudson

Forest Hill, Md.

March 3, 1958

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

Mar. 6 1958

Centre

Forest Hill

Md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

MAR 10 '58

Al Hudson

Martin G. Hunt Janesville Md.

INSTRUCTIONS

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VS AISC 1-55 10M

CERTIFICATE OF DEATH

See Dist. No.

1. DECEASED'S NAME (Last, first, middle)

2. SEX (Male or Female)

3. AGE (Years and months)

4. DATE OF BIRTH (Month, day, year)

5. PLACE OF BIRTH (City, town, village, or foreign country)

6. OCCUPATION (If deceased was engaged in any occupation)

7. CAUSE OF DEATH (If known, state the cause of death)

8. PLACE OF DEATH (City, town, village, or foreign country)

9. TIME OF DEATH (Hour, minute, second)

10. SIGNATURE OF DECEASED (If deceased was able to sign)

11. SIGNATURE OF WITNESSES (If deceased was unable to sign)

12. SIGNATURE OF PHYSICIAN (If deceased was under medical treatment)

13. SIGNATURE OF CORONER (If deceased was found dead)

14. SIGNATURE OF JURY (If deceased was found dead)

15. SIGNATURE OF JURY (If deceased was found dead)

16. SIGNATURE OF JURY (If deceased was found dead)

17. SIGNATURE OF JURY (If deceased was found dead)

18. SIGNATURE OF JURY (If deceased was found dead)

19. SIGNATURE OF JURY (If deceased was found dead)

20. SIGNATURE OF JURY (If deceased was found dead)

21. SIGNATURE OF JURY (If deceased was found dead)

22. SIGNATURE OF JURY (If deceased was found dead)

23. SIGNATURE OF JURY (If deceased was found dead)

24. SIGNATURE OF JURY (If deceased was found dead)

25. SIGNATURE OF JURY (If deceased was found dead)

26. SIGNATURE OF JURY (If deceased was found dead)

27. SIGNATURE OF JURY (If deceased was found dead)

28. SIGNATURE OF JURY (If deceased was found dead)

29. SIGNATURE OF JURY (If deceased was found dead)

30. SIGNATURE OF JURY (If deceased was found dead)

31. SIGNATURE OF JURY (If deceased was found dead)

32. SIGNATURE OF JURY (If deceased was found dead)

33. SIGNATURE OF JURY (If deceased was found dead)

34. SIGNATURE OF JURY (If deceased was found dead)

35. SIGNATURE OF JURY (If deceased was found dead)

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43. SIGNATURE OF JURY (If deceased was found dead)

44. SIGNATURE OF JURY (If deceased was found dead)

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BUREAU V. 1

MAR 10 1938

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Comptroller

For. 6-11-38

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3383

CERTIFICATE OF DEATH

Reg. Dist. No.

03371

1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Louis Henry Bunheim</i>				4. DATE OF DEATH <i>3/9/58</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/27/1909</i>	
9. AGE (In years, last birthday) <i>48</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mung Confectionery Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alfred Bunheim</i>				14. MOTHER'S MAIDEN NAME <i>Jessie Waterbury</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Mr. E. Elise Bunheim</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO <i>298.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Meningitis with Pulmonary Infection</i> (c) <i>Gastric Cancer - Bantu Disease Splenectomy</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>4 hours</i> <i>18 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>June</i> , 1938, to <i>March 9</i> , 1958, that I lost saw the deceased alive on <i>March 9</i> , 1958, and that death occurred at <i>5</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank Wolbert M.D.</i>				DATE SIGNED <i>March 11, 1958</i>			
PHYSICIAN'S NAME (Type) <i>FRANK WOLBERT M.D.</i>				ADDRESS (Street, city or town, state) <i>209 North Union Ave. Harford Grace Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>3/12/58</i>		<i>Angel Hill</i>		<i>Harford Grace Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kennington & Son, Harford Grace Md.</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 17 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. Search</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

BUREAU V. E.

MAR 17 1958

RECEIVED

Items 18-20 Film 227 4-14-58
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. **03372**

1. PLACE OF DEATH Harford COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) P. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 31	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aberdeen Proving Grounds		d. STREET ADDRESS 47 Aberdeen Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles W Clark		4. DATE OF DEATH Month March Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1909
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Chief		10b. KIND OF BUSINESS OR INDUSTRY Fire Department	
11. BIRTHPLACE (State or foreign country) Earlville, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James H. Clark		14. MOTHER'S MAIDEN NAME Gertrude VanDyke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Ralph Clark		Address 16 Fairview Avenue, Pennsville, NJ	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause Unknown (DOA) Presumably due to coronary 916.6 DUE TO occlusion while fighting a fire Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 30 min.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was inspecting the site of a fire for origin of fire 15min. earlier had been exposed to smoke inhalation & had to leave	
20c. TIME OF INJURY Month, Day, Year Hour o. m. Mar 8 1958 p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Building 3125	20f. (City or town) Aberdeen Proving Grounds Md.
21. I certify that I attended the deceased from 8 March , 19 58 to March 8 , 19 58 , that I last saw the deceased alive on _____, 19____, and that death occurred at 1130 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE William M. Michener M.D. Army Hospital, Aberdeen Prov Gd, Md. Mar 9, 1958 PHYSICIAN'S NAME (Type) William M. Michener Capt MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-11-58	22c. NAME OF CEMETERY OR CREMATORY CHESTER CEMTY	22d. LOCATION (City, town, or county) (State) CHESTERTOWN, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Victor H. Kennedy		ADDRESS STILL POND, MD.	24a. REC'D BY REGISTRAR DATE MAR 11 58
		24b. REGISTRAR'S SIGNATURE W. H. Kennedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Male		45		Jan 1, 1910		New York City		New York City		Heart Disease		Jan 15, 1958		10:00 AM		New York City		Natural		Dr. J. Doe		J. Doe		J. Doe	
Occupation		Marital Status		Education		Religion		Race		Color		Height		Weight		Blood Pressure		Temperature		Pulse		Respiration		Stomach		Intestines	
Teacher		Married		High School		Catholic		White		White		5' 10"		170 lbs		120/80		98.6		72		18		Normal		Normal	
Previous Illnesses		Previous Operations		Previous Accidents		Previous Injuries		Previous Trauma		Previous Burns		Previous Frostbite		Previous Poisoning		Previous Alcoholism		Previous Drug Use		Previous Mental Illness		Previous Physical Disability		Previous Chronic Disease		Previous Acute Disease	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	
Family History		Social History		Hobbies		Interests		Religious Activities		Political Activities		Military Service		Awards		Honors		Medals		Decorations		Other		Other		Other	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

MAR 11 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN lb <u>50</u> m	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arsena</u> Middle <u>Cooper</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June, 16, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>59</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Chambers</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Eliza Cooper, Bel Air R.D. #2 Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Bel Air Md</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 5, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>
22d. LOCATION (City, town, or county) <u>Churchville</u>		(State) <u>Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. McEwen Jr</u>		24a. REC'D BY REGISTRAR <u>Abingdon, Maryland</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>
DATE <u>MAR 5 '58</u>		DATE <u>MAR 5 '58</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3384

CERTIFICATE OF DEATH

Reg. Dist. No. 03374

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. CITY <u>Baltimore</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jennie Lee Daugherty</u>		4. DATE OF DEATH <u>3/16/58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/1876</u>
9. AGE (In years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Run, Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. S. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Peaco</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wm. Wm. Dorsey</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Cervix</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 19, 1957</u> , to <u>March 26, 1958</u> , that I last saw the deceased alive on <u>March 25, 1958</u> , and that death occurred at <u>7:50 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Stansbury</u>		ADDRESS (Street, city or town, state) <u>509 Revolution St., Harford Grace Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>3/28/58</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Spring</u>	22d. LOCATION (City, town, or county) (State) <u>Level Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conington M. Harrell</u>		24a. REC'D BY REGISTRAR <u>APR 1 '58</u>	
ADDRESS <u>Harrell</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
1933
CERTIFICATE OF DEATH

EX-100-10000

BUREAU V. 2

APR 1 1933

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3385 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>	c. LENGTH OF STAY IN 1b <u>1 hour</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> 31	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Old Port Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>George Finkernagel</u>	4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>14</u> Min. <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Finkernagel</u>		14. MOTHER'S MAIDEN NAME <u>Lizma</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-09-5132</u>	
17. INFORMANT <u>Geo Finkernagel Jr - Laureate Grace</u>		Address <u>see</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>812X</u> DUE TO (c) <u>812X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture L.T.B.I.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, antipede type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> p. m. <u>3-2-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Old Port Road</u>	20f. (City or town) <u>Aberdeen</u> (County) <u>Hartford</u> (State) <u>MD.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-3-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/5/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Laureate Grace MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarring</u>		24. REC'D BY REGISTRAR <u>see</u>	
25. REGISTRAR'S SIGNATURE <u>see</u>		DATE <u>MAR 6 '58</u>	

BUREAU V. S.

MAR 6 1959

RECEIVED

3406

CERTIFICATE OF DEATH

03376

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>				c. LENGTH OF STAY IN 1b <u>48 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1, X Rocks (Rural)</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Oleita</u> Middle <u>Baker</u> Last <u>Flowers</u>			4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23 1986</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Hartford, Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Baker</u>				14. MOTHER'S MAIDEN NAME <u>Oliza Amos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-183040</u>		17. INFORMANT <u>Howard Flowers - Rocks Rd Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 JAN</u> , 195 <u>6</u> , to <u>27 MAR</u> , 195 <u>8</u> , that I last saw the deceased alive on <u>13 MAR</u> , 195 <u>8</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thos. A. E. Moseley Jr.</u> M.D. <u>IT</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>28 MAR 1958</u>			
PHYSICIAN'S NAME (Type) <u>JARRETTVILLE Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Belair Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Madison E. K... Jarrettville Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

03377

CERTIFICATE OF DEATH

3407

Item 1 FilmG227 3-28-58 et

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Harford

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNDarlingtonLENGTH OF STAY
(in this place)
6 Years

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MarylandCOUNTY HarfordCITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNForest Hill

STREET ADDRESS

(If rural give location)

3. NAME OF DECEASED
(Type or Print)

(First)

(Middle)

(Last)

JamesGrace

4. DATE OF DEATH

(Month)

(Day)

(Year)

March 1319585. SEX
Male6. COLOR OR RACE
White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)
Married

8. DATE OF BIRTH

June 19, 18869. AGE last birthday
yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer10b. KIND OF BUSINESS OR INDUSTRY
Bairn11. BIRTHPLACE (State or foreign country)
Ash Co. M.C.12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

David L. Grace

14. MOTHER'S MAIDEN NAME

Malinda E. Proffitt15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-10-0833

17. INFORMANT & ADDRESS

Mrs. Gamu E. Grace

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

1420.1 IMMEDIATE CAUSE (A)

Coronary thrombosis27 hours

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

Chronic cardio-vascular disease10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Chronic bronchial asthma and emphysema.30 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

While ☐ Not while ☐at work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5, 190, to March 13, 1958, that I last saw the deceased alive on March 13, 1958, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

MAR 19 58W. BeachH. S. BaileyDarlington Md

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 OCCUPATION
 PLACE OF BIRTH
 MARITAL STATUS
 COLOR

CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF PHYSICIAN

TESTIFYING WITNESSES
 SIGNATURE OF CORONER
 SIGNATURE OF JURY

REMARKS
 SIGNATURE OF REGISTRAR
 DATE OF REGISTRATION

BUREAU V. 2

MAR 19 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3386

CERTIFICATE OF DEATH

Reg. Dist. No.

03378

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 3 yrs.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle May Last Gunther				4. DATE OF DEATH Month Mar. Day 28 Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 23, 1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) noe		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Everitt				14. MOTHER'S MAIDEN NAME Carr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Augustus Rembold, Aberdeen, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Metastasis with Infarction. DUE TO (c) Carcinoma of Stomach with metastasis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Disease of the Heart						INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 month 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 57 , to March , 19 58 , that I last saw the deceased alive on March 28 , 19 58 , and that death occurred at 1 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank Wolbert MD M.D.				ADDRESS (Street, city or town, state) 205 North Union St. Waco, Texas		DATE SIGNED 29/1958	
PHYSICIAN'S NAME (Type) FRANK WOLBERT MD				HANA DE GRACE Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 31, 1958		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McCormick Jr				ADDRESS Abingdon, Md.,		24a. REC'D BY REGISTRAR DATE APR 1 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3387

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03379

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>82</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Tull Gate Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Louise Hammond</u>		4. STREET ADDRESS <u>Tull Gate Road</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 13 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>John W. Chambers</u>		14. MOTHER'S MAIDEN NAME <u>Alice Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>L</u>	
17. INFORMANT <u>Alice A. Chambers</u>		Address <u>Bel Air Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture R. Humerus + ribcage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>260X</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus Atherosclerotic C. disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3:30</u> 19 <u>58</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		22d. LOCATION (City, town, or county) <u>Kalmar Harford</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		24a. REC'D BY REGISTRAR <u>Bel Air Md</u>	
ADDRESS <u>Bel Air Md</u>		24b. REGISTRAR'S SIGNATURE <u>Bel Air Md</u>	
DATE <u>MAR 7 '58</u>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
DEPT. OF HEALTH

RECEIVED
MAR 7 1958
BUREAU V. S.

8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3388

CERTIFICATE OF DEATH

Reg. Dist. No.

03380

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAYRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>15 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GRETTA</u> Middle <u>MARIE</u> Last <u>HERING</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>23 Sept. 1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brokerage</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CARROLL HERING</u>		14. MOTHER'S MAIDEN NAME <u>BURNETTA SHIPLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>General Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Carcinoma left breast</u> (b) <u>Terminal</u> (c) <u>6 mo.</u> <u>9 mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>9 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-15</u> , 19 <u>57</u> , to <u>3-10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-10</u> , 19 <u>58</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		ADDRESS (Street, city or town, state) <u>8 Law Street</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u> M.D.		<u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Finksburg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Finksburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Aberdeen</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. SMITH		45		M		W		JAN 15 1880		BALTIMORE, MD.	
MARRIED		WIFE		JANE D. SMITH		DAUGHTER		JOHN D. SMITH		SON	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
HEART DISEASE		NATURAL		HOME		JAN 20 1925		10:30 AM		10:30 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF MINISTER		SIGNATURE OF CLERGY	
J. H. SMITH		J. D. SMITH		J. D. SMITH		J. D. SMITH		J. D. SMITH		J. D. SMITH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		SIGNATURE OF PHYSICIAN	
JAN 20 1925		10:30 AM		HOME		NATURAL		HEART DISEASE		J. H. SMITH	

RECEIVED
MAR 5 1925
BUREAU V. S.

3390

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>8 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THERESA</u> Middle <u>M.</u> Last <u>HOLTER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1894</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William H. PIERCE</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Baumgart</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Leo Holter, Joppa, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation, recurrent</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic and Hypertensive Cardiovascular Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> <u>One Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 4th, 1958</u> to <u>March 15th, 1958</u> that I last saw the deceased alive on <u>March 5th, 1958</u> and that death occurred at <u>6:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Haver de Grace Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		DATE SIGNED <u>March 5th, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 8, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's</u>	22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. M. Brown</u>		24a. REC'D BY REGISTRAR DATE <u>Mar 11 1958</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 11 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3391

CERTIFICATE OF DEATH

Reg. Dist. No. 03383

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN RFD #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>1200 S. POST ROAD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE R HOMER</u>				4. DATE OF DEATH Month Day Year <u>MARCH 3 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/14/1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Singleton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sampson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>None</u>		17. INFORMANT Address <u>MRS Viole Battle Haure de Grace Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>March 2, 1958</u> to <u>March 3, 1958</u> , that I last saw the deceased alive on <u>March 3, 1958</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. J. Simon</u>				M.D. <u>Haure de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>				ADDRESS <u>HAURE DE GRACE, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Carney</u>				ADDRESS <u>Aberdeen Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>							

TO BE RELAYED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

10 1958

RECEIVED

3408

CERTIFICATE OF DEATH

Reg. Dist. No.

03384

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x-street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mary Rebecca Huff</u> First <u>Rebecca</u> Middle <u>Huff</u> Last		4. DATE OF DEATH <u>March 5</u> 19 <u>58</u> Month <u>March</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md</u>	
11. BIRTH PLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edwin R. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year of dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Clare Huff</u> Address <u>Street, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.4</u> DUE TO <u>Inanition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Jenkenia</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 3, 1958</u> to <u>March 5, 1958</u> , that I last saw the deceased alive on <u>March 3, 1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph A. Hunt</u> M.D.		ADDRESS (Street, city or town, state) <u>Leola, Pa</u> DATE SIGNED <u>3/6/58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph A. Hunt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>March 9 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harlington</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Harlington Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3499

CERTIFICATE OF DEATH

Reg. Dist. No.

03385

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Rural			c. LENGTH OF STAY IN 1b 15 yrs.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Calvary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle F. Last Ilgenfritz				4. DATE OF DEATH Month Mar. Day 26, Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1871		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Building Construction		11. BIRTHPLACE (State or foreign country) Monkton, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Ilgenfritz				14. MOTHER'S MAIDEN NAME Emma Folckenmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Elizabeth M. Ilgenfritz, Aberdeen R.D. 2, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Central Thrombosis DUE TO (b) Arterio-sclerotic Cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 9 days 12 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1957 to March, 1958 , that I last saw the deceased alive on March 24, 1958 , and that death occurred at 11:47 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. Ralph Horkey M.D. Churchville Md. March 27 PHYSICIAN'S NAME (Type) J. Ralph Horkey Churchville Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 29, 1958		22c. NAME OF CEMETERY OR CREMATORY Middletown		22d. LOCATION (City, town, or county) (State) Freeland, Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Brown Jr.				ADDRESS Abingdon Maryland		24a. REC'D BY REGISTRAR DATE Apr 1 '58	
				24b. REGISTRAR'S SIGNATURE Alfred...			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
JAMES H. HARRIS		JAN 15 1895	
RESIDENCE		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH	
APR 1 1933		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 1 1933		APR 1 1933	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
NAME OF WITNESS		NAME OF WITNESS	
J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 1 1933		APR 1 1933	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. S.

APR 1 1933

RECEIVED

3392

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Starford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Starford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Starve de Grace</i>		c. LENGTH OF STAY IN 1b <i>36 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>717 S. Union Ave</i>		d. STREET ADDRESS <i>717 S. Union Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>H.</i> Last <i>James</i>		4. DATE OF DEATH Month <i>3</i> Day <i>5</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 13, 1874</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>	11. BIRTHPLACE (State or foreign country) <i>Berkley, Maryland</i>
13. FATHER'S NAME <i>James James</i>		14. MOTHER'S MAIDEN NAME <i>Attie ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>217-12-8836</i>	
17. INFORMANT Address <i>717 S. Union Ave</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio Sclerosis - Chronic</i> DUE TO (c) <i>Nephritis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-20</i> , 19 <i>58</i> to <i>3-5</i> , 19 <i>58</i> that I last saw the deceased alive on <i>3-5</i> , 19 <i>58</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. L. Lewis M.D.</i>		ADDRESS (Street, city or town, state) <i>Starve de Grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>A. H. Lewis</i>		DATE SIGNED <i>3/4/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-9-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Berkley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Charles S. Bullock - Starve de Grace, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>3-10-58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Colman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM E. COLEMAN

BUREAU V. S.

18 10 1938

RECEIVED

3410

CERTIFICATE OF DEATH

Reg. Dist. No.

03387

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glendens Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glendens Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>B</u> Last <u>Donner</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co., Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo. B. Donner</u>		14. MOTHER'S MAIDEN NAME <u>Katharine Holloway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Geo. B. Donner</u>		Address <u>Harford, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-17</u> , 19 <u>57</u> , to <u>3-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-22</u> , 19 <u>58</u> , and that death occurred at <u>2:30 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harford, Md</u> DATE SIGNED <u>March 27, 1958</u>			
ACTUAL SIGNATURE <u>A. L. Lewis</u> M.D.		PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 26, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. A. Bailey</u> ADDRESS <u>Baltimore, Md</u>		24a. REC'D BY REGISTRAR <u>March 27 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3411 CERTIFICATE OF DEATH

03388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Road</u>		d. STREET ADDRESS <u>Paradise Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Helena</u> First <u>Karpov</u> Middle <u>—</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7th 1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Redko</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Boris Karpov, Aberdeen #2 rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u>			
420.1 DUE TO <u>Myocardial Infarction</u> <u>Terminal</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> <u>6 mo</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-19-</u> 19 <u>53</u> , to <u>3-8-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>2-27-</u> 19 <u>58</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>8 Law St., Aberdeen, Md.</u>			
DATE SIGNED <u>3-8-58</u>			
ACTUAL SIGNATURE <u>Peter P. Rodman, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Cremation</u>			
22b. DATE THEREOF <u>3/11/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>			
22d. LOCATION (City, lawn, or county) (State) <u>Baltimore Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Carving Aberdeen Md.</u>			
ADDRESS			
24a. REC'D BY REGISTRAR <u>Mar 13 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>			

CERTIFICATE OF DEATH

IN REPLY TO

BUREAU V. S.

MAR 12 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3393

CERTIFICATE OF DEATH

Reg. Dist. No. 03389

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURC de Grace</u>		c. LENGTH OF STAY IN 1b <u>18 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x PERRYMAN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>Box 87</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E.</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 2 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (carvers)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>F. Mitchell Bros.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William McDonald</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Witcomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-10-0391</u>		17. INFORMANT <u>Wife - Box 87 - Perryman rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastric Uicer</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-26-</u> , 19 <u>52</u> , to <u>3-12-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 12</u> , 19 <u>58</u> , and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter P. Rodman M.D.</u>				DATE SIGNED <u>3-13-58</u>			
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman M.D.</u>				ADDRESS (Street, city or town, state) <u>8 Law St. Aberdeen Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Sarring Aberdeen Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Sarring</u>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Md"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "3/10/1958"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	

BUREAU V. B.

MAR 17 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03390

3394

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre de Grace		c. LENGTH OF STAY IN 1b 32 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL		d. STREET ADDRESS 1839 ONTARIO	
3. NAME OF DECEASED (Type or print) First James Middle McEwing Last McEwing		4. DATE OF DEATH Month March Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 30, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher Western Union		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months 4 Days 19 Hours 58 IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LEVAN V. McEWING		14. MOTHER'S MAIDEN NAME ANNIE CORNELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 216-05-3710	
17. INFORMANT Mrs. Helen Kimball		Address HARRE DE GRACE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Chronic myocarditis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 3 , 19 57 , to March 4 , 19 58 , that I last saw the deceased alive on 3-4 , 19 58 , and that death occurred at 10:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. L. Lewis MD		ADDRESS (Street, city or town, state) Harre de Grace MD	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 7, 1958	22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		23d. LOCATION (City, town, or county) (State) HARRE DE GRACE MD	
24a. REC'D BY REGISTRAR MAR 6 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10

BUREAU V. 2

MAR 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3395

CERTIFICATE OF DEATH

Reg. Dist. No.

03391

1. PLACE OF DEATH a. COUNTY HARTFORD MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY HARTFORD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 15 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Havre de Grace (Rural)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARTFORD Memorial Hospital			e. STREET ADDRESS RD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Robert First Byrd Middle Miller Last			4. DATE OF DEATH Month March Day 5 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1950	9. AGE (In years last birthday) yrs. 7	IF UNDER 1 YEAR: Months 5 Days 5 Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME David R. Miller Jr.			14. MOTHER'S MAIDEN NAME Alice May Lichtenstein		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT David R. Miller Jr. R.D. 1 Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330x Subarachnoid Hemorrhage DUE TO (b) Rupture of basilar artery aneurysm Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) 20 hrs.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from March 5 , 19 58 , to March 6 , 19 58 , that I lost the deceased alive on 19 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Theodore H. Kaiser M.D.					
PHYSICIAN'S NAME (Type) THEODORE H. KAISER					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-8-1958	22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell			24a. REG'D BY REGISTRAR March 10 1958		
ADDRESS Havre de Grace Md.			24b. REGISTRAR'S SIGNATURE W. J. Smith		

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>March 10, 1958</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. MEDICAL HISTORY <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESSES <i>None</i>	
13. SIGNATURE OF DECEASED <i>None</i>		14. SIGNATURE OF NEXT OF KIN <i>None</i>		15. SIGNATURE OF BURIAL OFFICIAL <i>None</i>	
16. SIGNATURE OF FUNERAL HOME <i>None</i>		17. SIGNATURE OF CHURCH <i>None</i>		18. SIGNATURE OF OTHER <i>None</i>	

BUREAU V. S.

MAR 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03392

3412

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Parker Middle Mitchell Last Sr.				4. DATE OF DEATH Month March Day 15 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Feb. 1874	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canner		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick O. Mitchell				14. MOTHER'S MAIDEN NAME Eliza McGaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-28-3102		17. INFORMANT Parker Mitchell Jr.		Address Perryman, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arterio sclerotic Heart Disease DUE TO (c) Lobar Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:20AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andre Weiss		M.D.		ADDRESS (Street, city or town, state) 17 N. Phila Blvd.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Andre Weiss		M.D.		Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/18/58	22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		22d. LOCATION (City, town, or county) Perryman		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Farriey			ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 '58	24b. REGISTRAR'S SIGNATURE Al. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Date of Death		Place of Death	
Cause of Death		Occupation		Residence	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Time of Report		Place of Report	

BUREAU V. S.

MAR 19 1933

RECEIVED

Name of Deceased		Sex		Age	
Date of Birth		Date of Death		Place of Death	
Cause of Death		Occupation		Residence	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Time of Report		Place of Report	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G227 3-31-58 et

3396

CERTIFICATE OF DEATH

Reg. Dist. No.

03393

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wilmington</u> b. COUNTY <u>NEWCASTLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVEY DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 HRS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u>		d. STREET ADDRESS <u>BEACH EX 46 X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>Palandarini</u> Last <u>Palandarini</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 10. 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ITALY</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PASQUALE GROSSI</u>		14. MOTHER'S MAIDEN NAME <u>MARIA Amoto PASTORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alexander Palandini - Beach Wy 4</u>		Address <u>120 Brighton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute posterior Coronary thrombosis</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 years.</u> (c) <u>5 1/2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/10</u> , 19 <u>58</u> , to <u>3/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/11</u> , 19 <u>58</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		DATE SIGNED <u>3/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey de Grace</u>		24a. REGISTERED REGISTRAR <u>Wilmington</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH JAN 10 1958	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	

JAN 10 1958

BUREAU V. 3

MAR 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **03394**

FOR STATE
HEALTH DEPT.

M

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I

1. PLACE OF DEATH a. COUNTY Hanford		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 10 years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md		b. COUNTY Hanford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RD 1						e. STREET ADDRESS RD 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) James E Russell		4. DATE OF DEATH Month March Day 9 Year 1958		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-1889	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dan Thomas Russell		14. MOTHER'S MAIDEN NAME Susanna Shade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-32-7704		17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		EXAMINER'S NAME (Type) Gerald C Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-9-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF March 11-58		22c. NAME OF CEMETERY OR CREMATORY Union Chapel		22d. LOCATION (City, town, or county) (State) Bel Air, Md		23. FUNERAL DIRECTOR'S SIGNATURE Marion S. Kent ADDRESS Janet Wells			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Outboard		24c. DATE MAR 13 '58							

WATKINS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

STATE OF
NEW YORK

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

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PLACE OF BIRTH

BUREAU V. S.

MAR 13 1958

RECEIVED

3397

CERTIFICATE OF DEATH

03395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>RID # 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>DARE</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 4, 1887</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOILER FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAINBRIDGE</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Haynes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-16-3193</u>	
17. INFORMANT <u>ERNEST D. SMITH JR.</u>		Address <u>CONOVER RD. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 11, 1958</u> to <u>March 21, 1958</u> , that I last saw the deceased alive on <u>20 March, 1958</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Simon</u> M.D.		DATE SIGNED <u>March 21, 1958</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Earl Tyson</u> ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3398

CERTIFICATE OF DEATH

Reg. Dist. No.

03396

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre-de-Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>M.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-58</u>
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>6</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kenneth Smith</u>		14. MOTHER'S MAIDEN NAME <u>Murtle Smith (Simmons)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Kenneth W. Smith</u>		Address <u>638 N. Stokes St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> <u>576X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RETROPERITONEAL ABSCESS</u> DUE TO (c) <u>Origin of (b) unknown.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 10</u> , 19 <u>58</u> , to <u>March 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 16</u> , 19 <u>58</u> , and that death occurred at <u>10:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernice D. Hirsch</u>		ADDRESS (Street, city or town, state) <u>HARRE DE GRACE, MD.</u>	
PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u>		DATE SIGNED <u>3-17-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-19-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HARRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Harrede Grace Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

2071291XV5

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of informant		14. Address of informant		15. Telephone number	
16. Name of funeral home		17. Address of funeral home		18. Telephone number	
19. Name of cemetery		20. Address of cemetery		21. Telephone number	
22. Name of undertaker		23. Address of undertaker		24. Telephone number	
25. Name of physician		26. Address of physician		27. Telephone number	
28. Name of hospital		29. Address of hospital		30. Telephone number	
31. Name of nursing home		32. Address of nursing home		33. Telephone number	
34. Name of hospice		35. Address of hospice		36. Telephone number	
37. Name of funeral home		38. Address of funeral home		39. Telephone number	
40. Name of cemetery		41. Address of cemetery		42. Telephone number	
43. Name of undertaker		44. Address of undertaker		45. Telephone number	
46. Name of physician		47. Address of physician		48. Telephone number	
49. Name of hospital		50. Address of hospital		51. Telephone number	
52. Name of nursing home		53. Address of nursing home		54. Telephone number	
55. Name of hospice		56. Address of hospice		57. Telephone number	
58. Name of funeral home		59. Address of funeral home		60. Telephone number	
61. Name of cemetery		62. Address of cemetery		63. Telephone number	
64. Name of undertaker		65. Address of undertaker		66. Telephone number	
67. Name of physician		68. Address of physician		69. Telephone number	
70. Name of hospital		71. Address of hospital		72. Telephone number	
73. Name of nursing home		74. Address of nursing home		75. Telephone number	
76. Name of hospice		77. Address of hospice		78. Telephone number	
79. Name of funeral home		80. Address of funeral home		81. Telephone number	
82. Name of cemetery		83. Address of cemetery		84. Telephone number	
85. Name of undertaker		86. Address of undertaker		87. Telephone number	
88. Name of physician		89. Address of physician		90. Telephone number	
91. Name of hospital		92. Address of hospital		93. Telephone number	
94. Name of nursing home		95. Address of nursing home		96. Telephone number	
97. Name of hospice		98. Address of hospice		99. Telephone number	
100. Name of funeral home		101. Address of funeral home		102. Telephone number	

BUREAU V. B.

MAR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3414

Items 8, 9, 11, 12, 22, 3-31-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

03397

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, R.D. #2				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, R.D. #2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Charles Albert Stansbury				4. DATE OF DEATH Month Day Year March 10 19 58			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Feb. 1904	9. AGE (In years last birthday) 54 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman			10b. KIND OF BUSINESS OR INDUSTRY Railroad (APG.)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John W. Stansbury				14. MOTHER'S MAIDEN NAME Mary Pitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Chas. E. Stansbury R.D. 1 Md.		Address Havre de Grace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Inanition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abdominal Carcinomatosis DUE TO Carcinoma of Stomach (c) INTERVAL BETWEEN ONSET AND DEATH 1 wk 4 mo. 2 1/2 yr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-5-1950 , to 3-10-1958 , that I last saw the deceased alive on 3-10-1958 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter P. Rodman M.D.				ADDRESS (Street, city or town, state) 8 Law Street		DATE SIGNED	
PHYSICIAN'S NAME (Type) Peter P. Rodman M.D.				Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/58	22c. NAME OF CEMETERY OR CREMATORY Union Methodist		22d. LOCATION (City, town, or county) (State) Aberdeen, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE MAR 14 58	24b. REGISTRAR'S SIGNATURE W. H. Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3415

CERTIFICATE OF DEATH

Reg. Dist. No. 03398

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen R.D.				c. LENGTH OF STAY IN 1b 46 yrs.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Last Stein				4. DATE OF DEATH Month March , Day 15 , Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 18, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Home Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Md.,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Peter R. Stein				14. MOTHER'S MAIDEN NAME Carrie Bloomier			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-32-8351		17. INFORMANT Mamie Stein Address Aberdeen, R.D., Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal Cell Carcinoma - stomach 191.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 2 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug , 1957, to March , 1958, that I last saw the deceased alive on March 14 , 1958, and that death occurred at 1 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE T. Ralph Horky M.D.				ADDRESS (Street, city or town, state) Churchville, Md DATE SIGNED March 18			
PHYSICIAN'S NAME (Type) T. Ralph Horky				Churchville Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 18, 1958		22c. NAME OF CEMETERY OR CREMATORY Baker's		22d. LOCATION (City, town, or county) (State) Aberdeen, Harford, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs Jr				ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR DATE MAR 21 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 21 1958

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03399

CERTIFICATE OF DEATH

3416

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Maryland		COUNTY Cecil			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kalmia		LENGTH OF STAY (in this place) 7 months		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North East		07X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rd. # 1, Bel Air				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) George W. Stewart				4. DATE OF DEATH (Month) (Day) (Year) March 24 19 58			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH July 9, 1871	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Weaver		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Thomas Stewart				14. MOTHER'S MAIDEN NAME Annie Cownden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS James Stewart, Rd. #1, Box 238, Bel Air, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) Uremia						2 Weeks	
DUE TO ANTECEDENT CAUSE(S) (B) Prostatic hypertrophy						?	
DUE TO UNDERLYING CAUSE LAST (C) Chronic cardio-vascular-renal disease						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from October 30 19 57 , to March 24 19 58 , that I last saw the deceased alive on March 23 19 58 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.							
SIGNATURE Willard P. Hudson				ADDRESS (Street, city, town, state) M.D. Forest Hill, Maryland		DATE SIGNED March 25, 1958	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 27, 1958		NAME OF CEMETERY OR CREMATORY Methodist Cemetery		LOCATION (City, town, or county) (State) North East, Maryland	
24. REC'D BY REGISTRAR MAR 27 '58		REGISTRAR'S SIGNATURE Willard P. Hudson		25. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		ADDRESS Bel Air Maryland	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form 100-100

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED'S NEXT OF KIN

15. SIGNATURE OF DECEASED'S NEXT OF KIN

16. SIGNATURE OF DECEASED'S NEXT OF KIN

17. SIGNATURE OF DECEASED'S NEXT OF KIN

18. SIGNATURE OF DECEASED'S NEXT OF KIN

19. SIGNATURE OF DECEASED'S NEXT OF KIN

20. SIGNATURE OF DECEASED'S NEXT OF KIN

21. SIGNATURE OF DECEASED'S NEXT OF KIN

22. SIGNATURE OF DECEASED'S NEXT OF KIN

23. SIGNATURE OF DECEASED'S NEXT OF KIN

24. SIGNATURE OF DECEASED'S NEXT OF KIN

BUREAU V. B.

MAR 27 1938

RECEIVED

25. SIGNATURE OF DECEASED'S NEXT OF KIN

26. SIGNATURE OF DECEASED'S NEXT OF KIN

27. SIGNATURE OF DECEASED'S NEXT OF KIN

CERTIFICATE OF DEATH

Reg. Dist. No. 03400

3417

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Black Horse Rural</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall Monkton RD md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ha. Co. Convalescing Home</i>				d. STREET ADDRESS <i>R D</i>			
3. NAME OF DECEASED (Type or print) <i>Benjamin Horvey Sutton</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>M</i>				6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Aug 22 1868</i>				9. AGE (In years lost birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Co md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Elbridge Sutton</i>			
14. MOTHER'S MAIDEN NAME <i>Sarah E. Noremaker</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>---</i>				17. INFORMANT <i>Mrs Gertrude Dosh, Monkton RD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic & V disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>1-1</i> , 19 <i>58</i> , to <i>3-22</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>3-22</i> , 19 <i>58</i> , and that death occurred at <i>2A</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.				ADDRESS (Street, city or town, state) <i>Bel Air, Md.</i> DATE SIGNED <i>3-24-58</i>			
PHYSICIAN'S NAME (Type) <i>Gerald C Palmer MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>March 25-58</i>		<i>West Liberty</i>		<i>White Hall RD md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Martin E. Hunt</i> ADDRESS <i>Sanctiwell</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 27 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03401

FOR STATE
HEALTH DEPT.

3399

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo 07X.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FANE First Middle Last		4. DATE OF DEATH TAPP Month March Day 2 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/1913
9. AGE (in years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 7104C Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Frank T. Tapp		14. MOTHER'S MAIDEN NAME Evelyn Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-18-3721	
17. INFORMANT Marion Tapp Address Port Deposit, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/5/58	22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery	22d. LOCATION (City, town, or county) (State) Port Deposit R.D. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lea Patterson Son, ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR MAR 5 '58	24b. REGISTRAR'S SIGNATURE Alb...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE
MILITARY DEPT.

Anteriorly located cardiac disease

BUREAU V. S.

APR 5 1938

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3410 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03402

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. STREET ADDRESS <u>Maynoia</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond E. Tester</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-12</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Var.</u>	
11. BIRTHPLACE (State or foreign country) <u>Var.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ORLIE Tester</u>		14. MOTHER'S MAIDEN NAME <u>L. M. Ball</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>1-19-12</u>	
17. INFORMANT <u>Mrs. Raymond Tester</u>		Address <u>Peach Bottom Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture skull</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-pedestrian</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> a.m. <u>3-28</u> 1958 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US 40</u>		20f. (City or town) <u>Joppa</u> (County) <u>Hartford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Penn Hill Friends Cem.</u>		22d. LOCATION (City, town, or county) <u>Peach Bottom Lane Co, Penna.</u> (State) <u>PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Reynolds</u>		ADDRESS <u>Quarryville Pa</u>	
24a. REC'D BY REGISTRAR <u>APR 1 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3418 **CERTIFICATE OF DEATH**

03403

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		LENGTH OF STAY (in this place) <u>7 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>O.P.D. ACC, Edgewood, Md.</u>				STREET ADDRESS (If rural give location) <u>15 E. Cedar Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ralph</u> (Middle) <u>F.</u> (Last) <u>Tropea</u>				(Month) (Day) (Year) <u>Mar. 18 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10 June 1954</u>	9. AGE last birthday <u>3</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>9</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ralph F. Tropea Jr</u>				14. MOTHER'S MAIDEN NAME <u>Hara Shizuko xmi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT'S ADDRESS <u>Father 15 E. Cedar Drive Edgewood, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
085.1 IMMEDIATE CAUSE (A) <u>BILATERAL PNEUMONIA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Measles</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>0</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M. 7:00</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 15, 1958</u> , to <u>Mar. 15, 1958</u> , that I last saw the deceased alive on <u>Mar. 28, 1958</u> , and that death occurred at <u>A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John H. Tanning</u>		M.D. <u>ACC Edgewood, Md.</u>		ADDRESS (Street, city, town, state) <u>170A</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/25/58</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Army Chemical Center, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 27 '58</u>		REGISTRAR'S SIGNATURE <u>John H. Tanning</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tanning</u>		ADDRESS <u>Aberdeen, Md.</u>	

CERTIFICATE OF DEATH

Year Dis.

At Medical Examination Board of Health

At Medical Examination Board of Health

Edgewood

15 E. Cedar Drive

Maryland

15 E. Cedar Drive
Edgewood, Md.

At Medical Examination

BUREAU V. S.

MAR 27 1958

RECEIVED

Post Cemetery

3/27/58

Ex-101

Edgewood, Md.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03404

3419 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Street</i>		LENGTH OF STAY (in this place) <i>Lifetime</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Street</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>R.F.D. #2 Box 115</i>				STREET ADDRESS (if rural give location) <i>R.F.D. #2 Box 115</i>			
3. NAME OF DECEASED (Type or Print) <i>MILTON C. WATTERS</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>MARCH 5 1958</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>1-22-1905</i>	
				9. AGE last birthday <i>53</i> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <i>53</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Lock Port Pipe Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Walter Watters</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Kenly</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>218-07-0458</i>		17. INFORMANT & ADDRESS <i>R.F.D. #2 Box 115 Mrs. Sarah Barnes Street</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
150x IMMEDIATE CAUSE (A) <i>Carcinoma of Esophagus ?</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/8/58</i> , 19 <i>58</i> , to <i>3/5/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2/27/58</i> , 19 <i>58</i> , and that death occurred at <i>5:30 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Ruth Bullock</i>				ADDRESS (Street, city, town, state) <i>Forest Hill, Maryland</i>		DATE SIGNED <i>3/5/58</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-8-58</i>		NAME OF CEMETERY OR CREMATORY <i>Clark's Chapel Cem</i>		LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
24. REC'D BY REGISTRAR <i>MAR 10 '58</i>		REGISTRAR'S SIGNATURE <i>Alfred</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Bullock</i>		ADDRESS <i>Horne de G...</i>	

CERTIFICATE OF DEATH

REG. NO. 10

1. NAME OF DECEASED

MARYLAND

BIRTH OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF DEPUTY REGISTRAR

NAME OF DEPUTY CLERK

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BUREAU V. S.

MAR 10 1959

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3420

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DARLINGTON (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DARLINGTON (RURAL)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1 d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BARBARA E WEAVER</u>		4. DATE OF DEATH <u>MARCH 11 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3, 1957</u>
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR <u>9</u> Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>HARFORD COUNTY, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACK WEAVER</u>		14. MOTHER'S MAIDEN NAME <u>MARY HONAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MOTHER, Darlington, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA - 299X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRAIN DAMAGE FROM ANEMIA</u> DUE TO (c) <u>RH BLOOD DYSCRASIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 Hours</u> <u>7 MOS FROM BIRTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>AUGUST, 1958</u> , to <u>MARCH 10, 1958</u> , that I last saw the deceased alive on <u>MARCH 10, 1958</u> , and that death occurred at <u>1015AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		ADDRESS (Street, city or town, state) <u>307 Hickory</u> DATE SIGNED <u>March 11, 1958</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN M.D.</u>		<u>BEL AIR, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 13, 1958</u>	<u>Welcome Home Cem</u>	<u>Harford Co, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Darlington, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 13 '58</u>		<u>Alfred Smith</u>	

2071223XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 13 1959

RECEIVED

CERTIFICATE OF DEATH

03406

Reg. Dist. No.

3421

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BELAIR				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BELAIR			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1				d. STREET ADDRESS R.D. #1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE C. WILLIAMS				4. DATE OF DEATH Month Day Year MAR. 17, 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1872		9. AGE (In years and birthday) 85 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) LANCASTER Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID E. WILLIAMS				14. MOTHER'S MAIDEN NAME MARY E. HUTTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address R.C. WILLIAMS, BELAIR R.D. #1, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA, TERMINAL 450.0 DUE TO CARDIAC CONGESTIVE FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS of Old Age (85) (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 3 wks 1 year 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar , 19 57 , to Mar , 19 58 , that I last saw the deceased alive on Mar 10 , 19 58 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A.I. Sandecki M.D.				ADDRESS (Street, city or town, state) 15 Courtland Street DATE SIGNED 3.18.58			
PHYSICIAN'S NAME (Type) A.I. SANDECKI M.D.				Bel Air, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-23-58		22c. NAME OF CEMETERY OR CREMATORY SLATEVILLE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Harkins, Delta, Pa.				24a. REC'D BY REGISTRAR MAR 26 '58		24b. REGISTRAR'S SIGNATURE Al. Seach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 26 1958

BURMAN V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.